3 of 3

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07128

Reg. Dist. No. 203

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**
County: Kent
City or town: Piney Neck
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all life
Hospital, Institution, or street address where death occurred:
Rock Hall. Md.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Kent
City or town: Piney Neck
(If outside city or town limits, write RURAL and give nearest town)
Street No. Rock Hall
(If rural, give LOCATION)
2.(a) If veteran, name war: —

**3.(a) FULL NAME** Sarah E. Beck

**3.(b) Social Security Number** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widowed |

6.(b) Name of husband or wife: (Late) Samuel Beck
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 8 1868

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 78 | 8 | 22 | ..... hrs. ..... min. |

9. Birthplace: Kent Co. Md. (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business: home

FATHER
12. Name: Wm Waters
13. Birthplace: Kent Co. Md.

MOTHER
14. Maiden name: Jane Hitchens
15. Birthplace: Kent Co. Md.

16. Informant: Mrs. Riley Frazier
Address: Rock Hall. Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1, 1947 (month) (day) (year)
Cemetery or crematory: Ashley Burying ground
Location: Piney Neck

18. Funeral director: Marvin V. Williams
Address: Chestertown, Maryland

19. Sept. 1. 1947 (Date rec'd by registrar) S. Elwood Burgess Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: August 30 1947 at 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1947 to Aug 30 1947 and that I last saw h.. alive on Aug 30 1947.

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of face | |
| Metastasis of lungs | |
| Due to: Chron arthritis | |
| Due to: Chron Endo-myocarditis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: Albert G. Burgard M. D. or other
Address: Rock Hall, Md. Date signed: 8/31/47

# STATE OF MARYLAND—CERTIFICATE OF DEATH

07129

132

**1. PLACE OF DEATH**

County Kent Registration Dist. No. 201

Village or City Betterton No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 37 yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

**2. FULL NAME** Charles Edward Conwell If U. S. Veteran, specify WAR

(a) Residence: No. Betterton, Md. St., Ward

(Usual place of abode) If nonresident give city or town and State

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

## PERSONAL AND STATISTICAL PARTICULARS

| 3. SEX | 4. COLOR OR RACE | 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) |
|---|---|---|
| M | W | Married |

5a. If married, widowed, or divorced
HUSBAND of (or) WIFE of Sarah E. Conwell

6. DATE OF BIRTH (month, day, and year) July 22, 1881

| 7. AGE Yeers | Months | Deys | If LESS then 1 day, hrs. or min. |
|---|---|---|---|
| 66 | 0 | 25 | |

OCCUPATION

8. Trada, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. Carpenter

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Dete deceased last worked at this occupation (month and year) Oct. '46

11. Total time (years) spent in this occupation 37

12. BIRTHPLACE (city or town) Wilmington (State or country) Delaware

FATHER

13. NAME Charles Conwell

14. BIRTHPLACE (city or town) Unknown (State or country)

MOTHER

15. MAIDEN NAME Unknown

16. BIRTHPLACE (city or town) (State or country)

17. INFORMANT Sarah E. Conwell (Address) Betterton, Md.

18. BURIAL, ~~CREMATION OR REMOVAL~~ Place Chestertown Date Aug. 20, 1947

19. UNDERTAKER B. R. Fillows (Address) Still Pond Md

20. FILED Aug 19, 1947 J. H. Clark Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** August (Month) 16 (Dey), 1947 (Yeer)

22. I HEREBY CERTIFY, That I attended deceasad from July, 1947, to Aug 16th, 1947

I last saw h[illegible] alive on Aug 16 th, 1947; death is said to have occurred on the data stated ebove, at Aug 16 m. 3,30 P.M.

Tha PRINCIPAL CAUSE OF DEATH and ralated causes of importance were as follows:

| | Date of onset |
|---|---|
| Dilated Heart. | |
| Arterial Sclerosis | 6 mo. |
| | |
| | |
| | |
| Other Contributory Causes of importance: | |
| Brights Disease | 6 months |
| | |

Name of operation None Date of

Whet test confirmed diegnosis? Hospital Records Was there an autopsy? No

23. If death was due to external causas (VIOLENCE) fill in also the following:

Accident, suicida, or homicide? Dete of injury, 19

Whare did injury occur? (Specify city or town, county and State)

Specify whether injury occurrad in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Neture of injury

24. Was diseasa or injury in eny way related to occupetion of deceased?

If so, specify

(Signed) T. J. Aswell M. D.

(Address) Still Pond Md.

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |



ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

07130

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

**1. PLACE OF DEATH:**

County: Kent

City or town: Sandford Chestertown 3
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Res

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rustford
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Chestertown R.D. 3 mile
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3. (a) FULL NAME:** Frank Hill Gilpin

**3. (b) Social Security Number:** c

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | widowed |

6.(b) Name of husband or wife: Grace Hutchinson

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): June 26 1872

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 1 | 11 | ..... hrs. ..... min. |

9. Birthplace: Chestertown, Kent Co. Md
(Town, county, and state)

10. Usual occupation: Farmer Retired

11. Industry or business:

FATHER
12. Name: Joseph Gilpin
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emma M Beck
15. Birthplace: Maryland

16. Informant: Katherine Johnson, Daughter
Address: Rockville, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 8, 1947 (month) (day) (year)

Cemetery or crematory: St. Paul

Location: Near Fairlee Kent Co. Md.

18. Funeral director: Harris V. Williams

Address: Chestertown, Maryland

19. Aug. 8 1947 (Date rec'd by registrar) Clara S. Barnes Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6th 1947 at 4:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1940 to Aug. 6 1947 and that I last saw him alive on Aug. 4 1947

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Thrombosis | 10 yrs |
| Due to: Mitral Endocarditis (Rheumatic) | 10 years |
| Due to: | |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Frank N. Smith M. D. or other

Address: Chestertown Date signed: Aug 6/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

07131

## CERTIFICATE OF DEATH

Reg. Diat. No. 21021

**1. PLACE OF DEATH:**

County: Kent

City or town: Chestertown R.D. # 3

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 18 yrs.

Hospital, institution, or street address where death occurred:

Near Pomona

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Near Pomona

(If outside city or town limits, write RURAL and give nearest town)

Street No. Chestertown R.D. # 3

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Knut Arvid Gustafson

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6.(b) Name of husband or wife: Mathilda Gustafson

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.): November 16 1873

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 9 | 6 | hrs. min. |

9. Birthplace: Sweden (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farm

FATHER

12. Name: Unknown

13. Birthplace: "

MOTHER

14. Maiden name: Unknown

15. Birthplace: "

16. Informant: Mrs. Fred G. Gustafson

Address: Chestertown, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 25, 1947 (month) (day) (year)

Cemetery or crematory: Chester

Location: Chestertown, Maryland

18. Funeral director: Maurice V. Williams

Address: Chestertown, Maryland

19. Aug. 25, 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: August 22 1947, at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1947 to August 22 1947

and that I last saw him alive on August 22 1947

| Immediate cause of death | DURATION |
|---|---|
| Pulmonary Embolism | |
| Due to: Thrombophlebitis migrans, involving both legs + both arms | |
| Due to: | |
| Other conditions: Anemia; malnutrition; arteriosclerotic heart disease | |

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. R. Compda M.D.

M. D. or other

Address: Chestertown Md. Date signed: Aug 23, 1947

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07132

131a

## CERTIFICATE OF DEATH

Reg. Dist. No. 200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County: Plant 9

City or town: Rural Charlesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Plant 9

City or town: Rural Charlesville

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Georgianna Hankins

**3.(b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Married |

6.(b) Name of husband or wife: William Jenkins

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 10 1869

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 6 | 19 | hrs. min. |

9. Birthplace: Kennedysville Kent Md.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Thomas Ford

13. Birthplace: Md.

MOTHER

14. Maiden name: Nancy Jewell

15. Birthplace: Md.

16. Informant: William Jenkins Husband

Address: Rural Charlesville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 3 1947 (month) (day) (year)

Cemetery or crematory: Charlesville Cem.

Location: Rural Charlesville Md

18. Funeral director: Edward F. Maus

Address: Millington Md

19. Sept 1 1947 (Date rec'd by registrar) Edward F. Maus Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 1947 at 5 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947 to Aug 29 1947

and that I last saw her alive on Aug 27 1947

| | DURATION |
|---|---|
| Immediate cause of death: Uremia | 8 days |
| Due to: Chr Interstitial nephritis | 5 years |
| Due to: Arteriosclerosis | 5 y. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: Millington Date signed Sept 1-1947

07133

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932 B

## CERTIFICATE OF DEATH

Reg. Dist. No. 202

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**

County: Kent

City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months

Hospital, institution, or street address where death occurred:
Kent & Queen Anne Co. Hospital

How long in hospital or institution? 2 months

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Penna. County: Lancaster

City or town: Lancaster
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3.(a) FULL NAME:** (Miss) Hannah E. Middleton

**3.(b) Social Security Number:** no

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | white | single |

6.(b) Name of husband or wife: none

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 17, 1873

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 11 | 7 | ..... hrs. ..... min. |

9. Birthplace: Penna.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: H. A. Middleton
13. Birthplace: Penna.

MOTHER
14. Maiden name: Alice Middleton
15. Birthplace: Penna.

16. Informant: Mrs. Alice Whitworth
Address: Chestertown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 26, 1947 (month) (day) (year)

Cemetery or crematory: St. Paul Cemetery

Location: Kent Co. near Chestertown, Md.

18. Funeral director: J. Willis Wells

Address: Chestertown, Md.

19. Aug. 26, 1947 (Date rec'd by registrar) Clara L. Barnes. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: August 24 1947, at 4 00 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 1947, to August 24 1947 and that I last saw h-er alive on August 24 1947

| Immediate cause of death | DURATION |
|---|---|
| Congestive failure | 3 months |
| Due to Hyp. Cerebritis | ? |
| Due to Coronary sclerosis | ? |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. L. D. M. Jones M. D. or other

Address: Chestertown Md Date signed: 8/25/47

07134

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

1312 BC

Reg. Dist. No. 203

**1. PLACE OF DEATH:**

County: Kent

City or town: Rock Hall

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 3 m.

Hospital, Institution, or street address where death occurred: Denwick

How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Baltimore city

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. New Joyce Hotel, Cambden St

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

**3. (a) FULL NAME:** Katherine R. Reilly

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| fem | Wh. | married |

6.(b) Name of husband or wife: Michael Reilly

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): March 31 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 4 | 1 | hrs. min. |

9. Birthplace: Chestertown Md (Town, county, and state)

10. Usual occupation: House

11. Industry or business: —

FATHER — 12. Name: George Dill

13. Birthplace: Kent Co

MOTHER — 14. Maiden name: Fostina Woon

15. Birthplace: Kent Co.

16. Informant: Mrs Eug. Rainey

Address: Rock Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 4 1947 (month) (day) (year)

Cemetery or crematory: Louden Park Cemetery

Location: Baltimore Md.

18. Funeral director: Edgar L Lane

Address: Church Hill Md

19. 8/7 1947 (Date rec'd by registrar) S Elwood Burgess Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: August 1 1947, at 8:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1947, to Aug 1 1947 and that I last saw h... alive on July 31 1947

| Immediate cause of death | DURATION |
|---|---|
| Chron Nephritis | |
| Chron Endo-Myocarditis | |
| Due to: Decompensation | |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Albert A. Burgard M. D. or other

Address: Rock Hall, Md Date signed 8/10/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07135

Reg. Dist. No. 201

**1. PLACE OF DEATH:**

County: Kent

City or town: Rural Worton Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rural Worton Md
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Colemans
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME:** Elza Annie Sewell

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Widow |

6.(b) Name of husband or wife: William Sewell

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 16 1886

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 61 | 6 | 13 | hrs. min. |

9. Birthplace: Colemans Worton Md Rural
(Town, county, and state)

10. Usual occupation: Home maker

11. Industry or business

FATHER
12. Name: John Wilson
13. Birthplace: Worton Md Rural Colemans

MOTHER
14. Maiden name: Louisa White
15. Birthplace: Worton Md Rural Colemans

16. Informant: Rhoda Groves

Address: Worton Md Rural Colemans

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 31 1947 (month) (day) (year)

Cemetery or crematory: Colemans

Location: Worton Md Rural

18. Funeral director: B. K. Fellows

Address: Still Pond Md

19. Aug 31 1947 (Date received by registrar) J. H. Clark Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 29 1947, at 7.30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946, to Aug 29th 1947, and that I last saw h.er alive on Aug 29th 1947.

| | DURATION |
|---|---|
| Immediate cause of death: Paralysis of throat | 9 days |
| Contributory Cerebral Thrombosis | |
| Due to | |
| Due to | |
| Other conditions: Paralysis of R. Side | 8 months |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L. P. Atwell M. D. or other

Address: Still Pond Date signed: 8/30/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07136

48b

## CERTIFICATE OF DEATH

Reg. Dist. No. 204

**1. PLACE OF DEATH:**

County: Kent

City or town: Rock Hall Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? life

Hospital, Institution, or street address where death occurred:
Sharp Town

How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Kent

City or town: Rock Hall Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Sharp Town
(If rural, give LOCATION)

2.(a) If veteran, name war: —

**3. (a) FULL NAME:** Ida Gertrude Sisco

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Fem | col | widowed |

6.(b) Name of husband or wife: Wm. H. Sisco

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): May 8 1875

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 3 | 18 | ...hrs. ...min. |

9. Birthplace: Rock Hall, Md
(Town, county, and state)

10. Usual occupation: House

11. Industry or business: —

FATHER
12. Name: Hark Harris
13. Birthplace: Rock Hall, Md

MOTHER
14. Maiden name: Sarah Butler
15. Birthplace: Rock Hall, Md

16. Informant: Randolph Sisco
Address: Rock Hall, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28 1947 (month) (day) (year)

Cemetery or crematory: Sharptown

Location: Rock Hall, Md

18. Funeral director: Asbury Henry

Address: Chestertown, Md

19. Aug 28 1947 (Date rec'd by registrar) F. H. Smith Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: August 26 1947, at 12 15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 15 1947, to Aug 26 1947 and that I last saw h[illegible] alive on 8-23 1947

| Immediate cause of death | DURATION |
|---|---|
| Chron. Endo-Myocard. Fi | |
| Hypertension | |
| Due to: Carcinoma of uterus | |
| Due to: Ascites | |
| Other conditions: — | |

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: Albert G. Burgard M. D. or other

Address: Rock Hall, Md Date signed: 8/26/47

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

07137

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

117a

Reg. Dist. No. 2102

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Kent
City or town: Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 days
Hospital, institution, or street address where death occurred: Kent and Queen Annes
How long in hospital or institution? 4 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Kent
City or town: Chesterville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** John Truxon

**3.(b) Social Security Number**

| 4. Sex | 5. Color or race | 8.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | Black | Married |

6.(b) Name of husband or wife: Mary Truxon
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 18, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 0 | 13 | ..... hrs. ..... min. |

9. Birthplace: Hillsboro, Queen Anns, Md. (Town, county, and state)
10. Usual occupation: Retired farm laborer
11. Industry or business

FATHER
12. Name: Frank Truxon
13. Birthplace: Queen Anne County, Md

MOTHER
14. Maiden name: Henrietta Johnson
15. Birthplace: Queen Ann County, Md.

18. Informant: Hosp. Records
Address: Chestertown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 7, 1947 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Chesterville, Md.
18. Funeral director: Edward Fellows
Address: Millington, Md.

19 Aug. 4 1947 (Date rec'd by registrar) Clara L. Barnes, Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: August 3 1947, at 12:53 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 30 1947, to Aug. 3 1947
and that I last saw him alive on Aug. 3 1947

| | DURATION |
|---|---|
| Immediate cause of death: Chronic Myocarditis | 5 and 1/2 years |
| Due to: Terminal pneumonia | 24 hrs. |
| Due to: | |
| Due to: | |
| Other conditions: Bleeding gastric ulcer | 8 days? |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: A. A. Sick, M.D. (M. D. or other)
Address: Chestertown, Md. Date signed: 8-3-47

07138

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92b

## CERTIFICATE OF DEATH

Reg. Diat. No. 200

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

**1. PLACE OF DEATH:**
County Kent
City or town Rural Chestertown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Kent
City or town Rural Chestertown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Henrietta Ward

**3.(b) Social Security Number** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | Widowed |

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 1 1884

8. AGE: Years 63 | Months 5 | Days 28 | If less than one day hrs. min.

9. Birthplace Port Penn Del.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business

FATHER 12. Name unknown
13. Birthplace unknown

MOTHER 14. Maiden name Amanda Green
15. Birthplace Port Penn Del

18. Informant Owner Md
Address Rural Chestertown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 2 1947 (month) (day) (year)

Cemetery or crematory Penn
Location Rural Port Penn Del

18. Funeral director Edward Pellum
Address Millington Md

19. Sept 1 1947 Edward Pellum
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29th 1947, at 8 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1st 1947, to Aug 29th 1947 and that I last saw h alive on Aug 24th 1947

| Immediate cause of death | DURATION |
|---|---|
| Mitral Stenosis | 1 day |
| Due to Hypertension | 2 yr |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE G. F. Copeland M. D. or other
Address Millington Date signed Sept 1 47